DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165250	A. BUILDING _____ B. WING _____	C 11/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKMONT MANOR	1100 GRANDVIEW DRIVE, P O BOX 622 FLATWOODS, KY 41139

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey investigating ARO KY00015616 was initiated on 11/22/2010 and concluded on 11/24/2010. ARO KY00015616 was substantiated, and deficiencies cited with the highest S/S being a 'G'.	F 000	Oakmont Manor does not believe and does not admit that any deficiencies existed, either before, during or after the survey. Oakmont Manor reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings, or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is meant to establish any standard of care, contract obligation or position. Oakmont Manor reserves all rights to raise all possible contentions and defenses in any type to civil or criminal claim, action, or proceeding. Nothing contained in this plan of correction should be considered as a waiver or any potentially applicable peer review, quality assurance or self-critical examination privileges which Oakmont Manor does not waive, and reserves the right to assert in any administrative, civil, or criminal claim, action or proceeding. Oakmont Manor offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to our residents.	
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

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JAN - 4 2011
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Shanna Carver, Administrator — 1/4/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the physician was notified of a change in status for two (2) of nine (9) sampled residents (Residents #1 and #3). Residents #1 and #3 did not have adequate bowel elimination, as defined by the facility's bowel protocol, for periods ranging from four (4) to twenty (20) days. There was no documented evidence the facility's Bowel Care Protocol was implemented, including the notification of the resident's physician when the resident failed to have bowel movements. Although interview and record review revealed Resident #1 did not have regular bowel movements, there was no evidence the resident's physician was notified regarding the resident's lack of bowel movements. Resident #1 was admitted to the hospital on 10/16/10, with diagnoses including constipation and fecal impaction. The findings include: Review of the facility's Bowel Care Protocol (BCP), which was not dated, revealed a resident must have at least one (1) large or two (2) medium bowel movements every three (3) days to be considered adequate. According to the facility's Bowel Care Protocol, if three (3) days elapsed without adequate bowel elimination bowel movements, the following steps should be taken, beginning with Step 1, then 2 and so forth:	F 157	It is and was on the day of survey the policy of Oakmont Manor to immediately inform resident, consult with the resident's physician and if known, notify the legal representative of a need to alter treatment significantly. 1. Resident #1 no longer resides at Oakmont Manor. Resident #3's physician has been notified of bowel elimination pattern and treatment plan is in place. Completed on November 29, 2010 by Unit Coordinator. 2. All residents bowel elimination logs have been reviewed to ensure proper bowel elimination has been achieved and physician was notified of any issues identified. This was completed on November 29th by the unit coordinator and reviewed by QA nurse and DON. As of November 29th, The Quality Assurance nurse and Director of Nursing review all daily shift reports and physician's orders to ensure the resident's physician has been notified of any need to alter treatment significantly.	

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F 157	Continued From page 2 1. Milk of Magnesia (M.O.M.) 30 ml po, if no results in 24 hours, 2. Dulcolax Suppository 10 mg rectally, if no results in 12 hours, 3. Fleets Enema, 4. If no results, or inadequate results, with Fleets Enema, 1000 ml soap suds enema x 2, if still inadequate results, notify Physician. Review of the facility's Changes in a Resident's Condition or Status Policy revealed the Physician was to be notified of changes in the resident's condition and/or status. 1. Review of the clinical record revealed Resident #1 was admitted with diagnoses which included Diabetes, Hypertension, Peripheral Vascular Disease, Coronary Artery Disease, and Chronic Renal Failure requiring Hemodialysis. Review of the Bowel Information Tracking Logs for September and October of 2010 revealed no documented evidence Resident #1 had a bowel movement for the eleven (11) day period between 09/24/10 and 10/04/10. Continued review revealed the resident had a medium bowel movement on 10/07/10, a small bowel movement on 10/10/10, and a small bowel movement on 10/19/10. Application of the facility's bowel protocol to Resident #1's bowel record revealed the resident did not have an adequate bowel movement for twenty (20) days, from 09/24/10 to 10/14/10. Continued review revealed no evidence the resident's physician was notified of the resident's lack of bowel movements.	F 157	3. An in-service was conducted on December 6th, by the Director of Nursing for all licensed nursing staff reviewing physician notification requirements. 4. As part of the facility's ongoing Quality Assurance Program the Director of Nursing and/or the Quality Assurance nurse will review bowel elimination records daily and will review all MD orders and shift reports to ensure any significant change in needs of resident are reported to the MD. The results of the audit will be reviewed by the Quality Assurance Committee on a monthly basis for six months to determine compliance. December 7, 2010	

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F 157	Continued From page 3 Interview with the attending physician on 11/24/10 at 4:45 PM revealed he had never received a call from the facility related to the resident's constipation or lack of bowel movements. Review of the Nurse's Notes dated 10/06/10 at 1:00 AM, and signed by Registered Nurse (RN) #1, revealed Resident #1 complained of constipation and received Lactulose earlier in the shift. Continued review revealed the resident told the nurse he/she would need an enema if the Lactulose did not work. Review of Nurse's Notes for the remainder of the shift revealed no indication of the results following the Lactulose, no evidence the physician was notified, and no report of an enema being offered to the resident. Interview with Registered Nurse (RN) #1 on 11/24/10 at 3:45 PM revealed she recalled Resident #1 complained, "one night" of constipation and needed an enema. The nurse stated she called the doctor, who said she could give an enema, which she attempted to administer. The RN explained the resident refused the enema and said, "I don't want it, it wouldn't help anyway." Continued interview revealed RN #1 recalled finding a container of glycerine suppositories on the resident's bedside table. She stated she locked the medication in the medication cart and advised the resident she would obtain a physician's order for the suppositories, but did not call the physician to obtain the order. Review of the Nurse's Notes dated 10/16/10 at 5:00 PM revealed Resident #1 complained of "pain in stomach, just not feeling well, nausea, chills." Continued review revealed the resident had a temperature of 101.1 degrees Farenheit	F 157		

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F 157	Continued From page 4 and the spouse requested the resident be sent to the hospital. Further review of the Nurse's Notes revealed the resident was sent to the hospital, by ambulance, at 5:15 PM. Further review revealed a call was received from the hospital at 11:30 PM, informing the facility the resident had been admitted with abdominal pain and constipation. During interview, on 11/23/10 at 9:30 AM, Resident #1 reported a long history of constipation which required the use of five (5) to six (6) Colace tablets (a stool softener) twice a day. The resident reported the use of a "Fleets" suppository "at least twice a week." Further interview revealed Resident #1 reported he/she "begged them every day" to get an order for a "Fleets" suppository. The resident stated different nurses said they would contact the doctor for an order, but the resident did not believe they did because no suppositories were ever administered. The resident stated, "I begged them, they ignored me. They let me lay there and almost die. If it wasn't for my (spouse), I would have died. Now here I lie." Interview with the spouse of Resident #1 on 11/23/10 at 2:30 PM revealed Resident #1 was admitted to the hospital on 10/16/10.. Continued interview revealed the spouse had spoken to the resident's surgeon after Resident #1 underwent surgery on 10/21/10. The spouse reported being told by the surgeon the resident's bowel had burst. In addition, the spouse stated he/she was told the resident was so impacted, the bowel was dead and the resident required placement of a colostomy. Further interview revealed the spouse had spoken to the resident's attending physician, who had cared for the resident at the nursing home, and the physician reported he had never	F 157		

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F 157	Continued From page 5 been called by facility staff about the resident's lack of a bowel movement. The spouse further stated different nurses at the facility said they would call the doctor, but they never did. During interview on 11/24/10 at 4:45 PM, the attending physician for Resident #1 stated he had spoken to the surgeon, who reported the resident had a fecal impaction on admission to the hospital, with perforation of the bowel after admission to the hospital requiring surgical intervention. 2. Review of Resident #3's clinical record revealed an admission date of 05/18/09 with diagnoses which included Dementia with Delusions and Constipation. Review of the August-November 2010 Monthly Physicians Orders revealed an order for Lactulose (laxative) 30 milliliters (ml) by mouth once daily as needed due to constipation and an order for Bisacodyl (Dulcolax) 10 milligrams (mg) suppository rectally once daily as needed for constipation. Review of the August 2010 Bowel Information Tracking Log revealed no documented evidence of a BM from August 29-31 (3 days). Review of the September, October and November 2010 Bowel Information Tracking Logs revealed no documented evidence of adequate BMs, as defined by the facility's bowel protocol, from September 15-October 2 (18 days), October 8-17 (10 days), and October 19-22 (4 days). Further review revealed no documented evidence of adequate BMs from October 26-November 5 (11 days) and November 8-23 (16 days).	F 157		

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F 157	Continued From page 6 Review of the August-November 2010 Nurses Notes revealed no documented evidence that the Physician was notified of the resident's condition or status regarding bowel elimination. Interview on 11/24/10 at 10:30 PM with Licensed Practical Nurse #1 revealed the Bowel Care Protocol was not followed. Resident #3 should have received Lactulose, Dulcolax, and Fleets enema several times. She stated she was unable to find documentation the Physician was notified of the change in bowel elimination.	F 157		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure necessary care and services were provided for the residents' physical well-beings for four (4) of nine (9) sampled residents (Residents #1, #3, #4, and #7). Resident #1 did not have adequate bowel elimination, per facility protocol, for twenty (20) days. As a result, Resident #1 was admitted to the hospital with a severe fecal impaction. During the hospitalization, the resident suffered a perforated bowel with sepsis, and required placement of a colostomy.	F 309	It is and was on the day of survey the policy of Oakmont Manor to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. 1. Resident #1 no longer resides at Oakmont Manor. Residents #3, #4, and #7 have a routine bowel pattern established. This was completed on November 29th by the Unit Coordinator. 2. All resident's bowel flow sheets have been reviewed to ensure an acceptable bowel pattern. This was reviewed by the QA nurse on November 29, 2010.	

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F 309	Continued From page 7 There was no documented evidence Resident #3, #4 and #7 experienced bowel movements for periods ranging from four (4) to eighteen (18) days. There was no documented evidence the facility followed its Bowel Care Protocol regarding the administration of medications and notification of the physician for residents who did not have regular bowel movements. The findings include: Review of the facility's Bowel Care Protocol (BCP), which was not dated, revealed a resident must have at least one (1) large or two (2) medium bowel movements every three (3) days, to be considered adequate. According to the facility's Bowel Care Protocol, if a resident has gone three (3) days without adequate bowel elimination one large or two medium bowel movements the nurse should implement treatment as follows: 1. Milk of Magnesia 30 milliliters (ml) by mouth (po), and if no results in 24 hours, 2. Dulcolax Suppository 10 milligrams (mg) rectally, and if no results in 12 hours, 3. Fleets Enema. 4. If no results, or inadequate results, with Fleets Enema, 1000 ml soap suds enema x 2, and if still inadequate results, notify Physician. 1. Review of Resident #1's closed record revealed an admission date of 09/24/10 and diagnoses which included Diabetes, Coronary Artery Disease, and Chronic Renal Failure, which required Hemodialysis. Review of the Admission Minimum Data Set (MDS) Assessment dated 10/06/10, revealed the	F 309	3. Daily the charge nurse will review the bowel sheets and implement the bowel program for any resident who has not had an adequate bowel movement in three days. An in-service was conducted by the Director of Nursing for all licensed staff on December 1st , to review the Bowel Protocol. 4. As part of the facility's ongoing Quality Assurance Program the QA nurse will monitor the bowel sheets every Monday and Thursday for a period of six months to ensure all residents are having bowel movements at least every three days. Results of the aforementioned audits will be reviewed by Quality Assurance Committee monthly for six months to determine compliance. December 2, 2010	

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F 309	Continued From page 8 facility assessed the resident as being able to complete the Brief Interview for Mental Status satisfactorily and did not require further assessment of cognitive status. Review of the Functional Status portion of the MDS revealed the facility assessed the resident as being totally dependent on staff for toileting. In addition, the facility assessed the resident as not having constipation. However, review of the Nursing Assessment Quarterly Summary dated 10/06/10, revealed bowel constipation was present. Review of the Bowel and Bladder Evaluation section of the Admission Nursing Assessment dated 09/24/10, revealed Resident #1 was assessed as being continent of bowel. However, the facility failed to identify the presence of constipation, the use of laxatives and/or enemas, and the date of the resident's last bowel movement as components of the assessment. Review of admission Physician's Orders revealed Resident #1 had an order, dated 09/24/10, for Senokot at bedtime, as needed for constipation. In addition, a physician's telephone order for Lactulose (a laxative), to be given daily as needed, was received on 10/05/10. Review of the Bowel Information Tracking Log for September 2010 revealed no documented evidence Resident #1 had a bowel movement between 09/24/10 and 09/30/10. Review of the Bowel Information Tracking Log for October 2010 revealed the resident had a small bowel movement on 10/04/10, eleven (11) days after admission to the facility. Continued review revealed the resident had a medium bowel movement on 10/07/10, a small bowel movement on 10/10/10, and a small bowel movement on	F 309		

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F 309	Continued From page 9 10/13/10. The resident was noted to have had a large bowel movement on 10/14/10. According to the log, Resident #1 failed to have an adequate bowel movement for twenty (20) days, from 09/24/10 to 10/14/10, as identified by the facility's policy. Review of the Medication Administration Record (MAR) revealed the resident could be administered Lactulose (laxative) every day, as needed for constipation, however the resident received the Lactulose on 10/05/10 at 11:45 AM, and 10/08/10 at 1:00 PM only. Continued review of the MAR revealed the resident could be given Lactulose every day as needed for constipation, and Senokot at bedtime as needed for constipation. Further review revealed there was no documented evidence the Senokot was given throughout the resident's stay; and there was no documented evidence a Dulcolax suppository, a "Fleets" enema, or a soap suds enema were ever given. Review of the Nurses Notes dated 10/06/10 at 1:00 AM, and signed by Registered Nurse (RN) #1, revealed Resident #1 complained of constipation and received Lactulose earlier in the shift. Continued review revealed the resident told the nurse an enema may be needed if the Lactulose didn't work. Review of subsequent Nurses Notes for the shift and for the following days revealed no further reference to the resident's complaint, results following the Lactulose, the administration of an enema, or notification of the physician regarding the resident's lack of adequate bowel movements. Interview with RN #1 on 11/24/10 at 3:45 PM revealed she recalled Resident #1 complained	F 309		

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F 309	Continued From page 10 "one night" of constipation and needed an enema. The nurse stated she called the doctor, who said she could give an enema. She further stated she attempted to administer the enema to the resident, who then refused it by saying "I don't want it, it wouldn't help anyway." RN #1 stated she told the resident she would get a physician's order for the suppositories. She further stated she did not call the physician herself, but passed it along in report. RN #1 was unable to recall Resident #1 ever having a bowel movement, during the resident's stay at the facility. Interview with Certified Nursing Assistant (CNA) #2 on 11/24/10 at 9:40 AM and CNA #1 on 11/24/10 at 10:10 AM, revealed they had provided care to this resident but could not recall Resident #1 voicing concerns related to being constipated. Neither of the CNAs could recall the resident having a bowel movement during his/her stay at the facility. Interview, on 11/24/10 at 12:40 PM with Licensed Practical Nurse (LPN) #1, who provided care to this resident, revealed she did not recall if Resident #1 had any complaints related to constipation or not having a bowel movement. LPN #1 indicated she did not recall the resident requesting a suppository. Interview, on 11/14/10 at 4:55 PM, with the Unit Manager (UM), where Resident #1 resided, revealed the Bowel Protocol should be initiated for any resident who did not have a bowel movement in three (3) days. She stated the administration of PRN (as needed) medications should be documented on the MAR. The UM explained she reviewed the bowel logs three (3) times a week but had not identified a problem	F 309		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKMONT MANOR	1100 GRANDVIEW DRIVE, P O BOX 622 FLATWOODS, KY 41139

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11 with Resident #1, or the lack of bowel movements. After reviewing the Bowel Tracking Information Log with the surveyor, the Unit Manager expressed surprise the resident had gone so long without a documented bowel movement. She further stated she did not recall Resident #1 complaining of constipation or asking for an order for a suppository. Review of the Physical Therapy Progress Report dated 10/07/10 revealed after therapeutic exercises Resident #1 "began to cry with abdominal pain from lack of bowel movement." Interview with the Therapy Assistant on 11/24/10 at 11:10 AM revealed she only saw Resident #1 twice. She recalled the resident said she was really constipated and stated, "my stomach is killing me, I'm constipated." During a follow-up interview on 11/24/10 at 4:00 PM, the Therapy Assistant stated she did not recall reporting the resident's complaints to nursing staff. Review of the Nurse's Notes dated 10/16/10, at 5:00 PM revealed Resident #1 complained of "pain in stomach, just not feeling well, nausea, chills." Continued review revealed the resident had a temperature of 101.1 degrees Farenheit. The spouse requested the resident be sent to the hospital. The Nurse's Notes revealed the resident was sent to the hospital, by ambulance, at 5:15 PM. The Note indicated a call was received from the hospital at 11:30 PM, informing the facility the resident had been admitted with abdominal pain and constipation. Review of the hospital record revealed Resident #1 was admitted to the Intensive Care Unit on 10/16/10 with diagnoses which included Abdominal Pain and Constipation. Review of	F 309		

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F 309	Continued From page 12 Emergency Room records revealed the resident complained of abdominal pain rated with a severity of eight (8) on a scale of ten (10). Review of the abdominal x-ray dated 10/16/10, revealed a "markedly large amount of stool in the rectosigmoid portion of the colon most consistent with severe constipation/impaction." Review of the Computerized Tomography (CT) scan of the abdomen dated 10/16/10 revealed "severe impaction of the rectosigmoid with stool." The hospital's History and Physical (H&P) dated 10/17/10, was reviewed and revealed the physician assessed the resident to have severe constipation. The resident was noted to have been anxious, with abdominal pain and sluggish bowel sounds. A rectal exam revealed hard stool in the rectum. At the time of dictation of the H&P, the resident had received two (2) Fleets enemas with results of two (2) moderate bowel movements. Review of the Surgical Consult dated 10/18/10 revealed Resident #1 had a "severe stool impaction." Aggressive laxative therapy was initiated. The Surgical Consult dated 10/18/10 revealed Resident #1 had a bowel-to-bladder fistula (a connection between the intestine and the bladder which allowed fecal material to spill into the bladder). In addition, the resident was diagnosed with sepsis, a condition of "destruction of tissues caused by disease-causing bacteria or their toxins" (The Bantam Medical Dictionary, 2009). Review of the Infectious Disease consult dated 10/18/10, revealed Resident #1 was assessed to have severe constipation, severe abdominal pain	F 309		

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	185260	A. BUILDING _____ B. WING _____	C 11/24/2010

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F 309	Continued From page 13 "worrisome for perforated bowel", and sepsis. The Operative Report dated 10/21/10 was reviewed and revealed Resident #1 underwent an Exploratory Laparotomy. Continued review revealed feculent peritonitis (inflammation due to contamination with feces) was present throughout the abdomen. Two (2) liters of purulent (pus-filled) fluid was suctioned out. A Colovesical (bowel-to-bladder) fistula was identified, with the bladder containing fecal material as well. A colectomy with colostomy was performed, the fistula was repaired, and a supra-pubic urinary catheter was placed. During interview on 11/24/10 at 4:45 PM, the attending physician for Resident #1 stated he had spoken to the surgeon, who reported the resident had a fecal impaction with perforation of the bowel. The attending physician denied having received a call from the facility related to the resident's constipation or lack of bowel movements. An interview was conducted with Resident #1, on 11/23/10 at 9:30 AM, at the nursing home he/she resides at this time. During the interview the resident expressed having a long history of constipation which required the use of five (5) to six (6) Colace tablets (a stool softener) twice daily. In addition, the resident reported the use of "Fleets" suppository "at least twice a week." The resident expressed having a history on going four (4) days without a bowel movement. The resident stated, "I knew I had to stay on it, that's why I took so much Colace." Further interview revealed Resident #1 reported he/she "begged them (facility staff) every day" to get an order for a Fleet's suppository. The resident stated, "I	F 309		

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F 309	Continued From page 14 begged them, they ignored me. They let me lay there and almost die. Interview with Resident #1's spouse, on 11/23/10 at 2:30 PM, revealed Resident #1 was admitted to the hospital on 10/16/10. The spouse indicated he/she had spoken to the resident's surgeon after Resident #1's surgery and was told the resident's bowel had burst. According to the spouse, the surgeon further reported the resident was so impacted, the bowel was dead and the resident required a colostomy. Further interview revealed the spouse had spoken to the resident's attending physician, who had cared for the resident at the nursing home, and the physician reported no one had ever called him about the resident's lack of a bowel movement. 2. Review of Resident #3's clinical record revealed diagnoses which included Dementia with Delusions and Constipation. Review of the August-November 2010 Monthly Physicians Orders revealed an order for Lactulose (a laxative) thirty (30) ml by mouth once daily as needed due to constipation and an order for Bisacodyl (a laxative) 10 mg Suppository rectally once daily as needed for constipation. Review of the August 2010 Bowel Information Tracking Log revealed no documented evidence of a Bowel Movement (BM) from August 29-31 (3 days). Review of the Medication Administration Record (MAR) revealed no documented evidence the prescribed medications were provided to the resident. Review of the September and October 2010 Bowel Information Tracking Logs revealed no	F 309		

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F 309	Continued From page 15 documented evidence of adequate BMs, as described by the facility's policy, from September 15-October 2 (18 days), October 8-17 (10 days), and October 19-22 (4 days) and review of the September and October 2010 MAR revealed no documented evidence that the prescribed medications were given. Review of the October and November 2010 Bowel Information Tracking Logs revealed no documented evidence of adequate BM's from October 26-November 5 (11 days) and November 8-23 (16 days). Review of the October and November MAR revealed Lactulose was given on 11/04/10 and 11/06/10. There was no documented evidence any other bowel medications were administered. Interview on 11/24/10 at 10:30 PM with Licensed Practical Nurse #1 revealed Bowel Care protocol was not followed. The nurse stated according to the Bowel Care Protocol, Resident #3 should have received Lactulose, Dulcolax, and Fleets enema several times. LPN #1 stated the Certified Medication Technicians (CMT) examine the bowel logs daily, give the Lactulose when needed and notify the nurse when it was given. She further stated she was unable to find documentation regarding the Physician being notified of the change in bowel elimination for Resident #3. 3. Review of the clinical record revealed Resident #4 was admitted on 06/30/10 with diagnoses which included Ovarian Cancer and Nausea/Vomiting. Review of the Significant Change Admission Minimum Data Set (MDS) Assessment dated 09/11/10, and Admission MDS Assessment dated	F 309		

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F 309	Continued From page 16 07/13/10 revealed the facility assessed the resident as having constipation. Review of the Comprehensive Plan of Care dated 09/16/10, revealed the resident was at risk for constipation due to decreased mobility and "routine" use of pain medications. The Plan of Care revealed interventions which included: administering medications as ordered, monitoring bowel movement (BM) each shift, and reporting if no BM every two (2) to three (3) days. Review of a Computed Tomography (CT) Scan report, dated 09/07/10 revealed findings which included probable constipation and fecal impaction. Review of the August, September, October, and November 2010 Monthly Physician Orders revealed orders for Fiberglas (bulk-forming laxative for constipation) tablet every day and Bisacodyl (laxative for constipation) 10 milligram rectal suppository every three (3) days. Continued review revealed orders for Lactulose (synthetic sugar laxative for constipation) thirty (30) milliliters by mouth every four (4) hours PRN (as needed), Bisacodyl ten (10) milligram rectal suppository every day PRN and Enema disposable Fleet type (saline laxative for constipation) once daily PRN. Review of Resident #4's August, September, October and November 2010 Bowel Information Tracking Logs revealed no documented evidence of adequate (per the facility's policy) bowel elimination from 08/13/10 through 08/19/10, seven (7) days; from 08/31/10 through 09/06/10, seven (7) days; 09/23/10 through 09/29/10 seven (7) days; 09/30/10 through 10/06/10, seven (7)	F 309		

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F 309	Continued From page 17 days; and 10/27/10 through 11/02/10, seven (7) days. Review of the resident's medical record revealed no documented evidence the facility implemented the Bowel Care Protocol, including administration of as needed bowel medications, or notification of the resident's physician when the resident did not have adequate bowel movements. 4. Review of Resident #7's clinical record revealed diagnoses which included Osteoarthritis, Diabetes Mellitus and Bilateral Knee Replacement. Review of the Annual Minimum Data Set (MDS) Assessment dated 04/16/10, revealed the facility assessed Resident #7 as having moderate impairment in cognitive skills and requiring extensive assistance with most Activities of Daily Living. Further review of the resident's MDS Assessment revealed the facility assessed the resident as having no constipation. Review of the Comprehensive Plan of Care dated 10/15/10 revealed the resident had Impaired Bowel Elimination with Occasional Constipation. The interventions included; administering medication as ordered; monitoring bowel movement (BM) each shift, and reporting if no BM every two (2) to three (3) days. Review of the October and November 2010 Monthly Physician Orders revealed orders for Lactulose (a laxative) twenty (20) milliliters by mouth as needed for constipation and Bisacodyl ten (10) milligram rectal suppository once a day as needed for constipation.	F 309		

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F 309	Continued From page 18 Review of Resident #7's October 2010 and November 2010 Bowel Information Tracking Logs revealed no documented evidence of adequate (as noted in in the facility's policy) bowel elimination from 10/10/10 through 10/14/10, five (5) days; 10/16/10 through 10/19/10, four (4) days; 10/21/10 through 10/26/10, six (6) days; 10/28/10 through 11/03/10 seven (7) days; 11/06/10 through 11/10/10, five (5) days; and 11/17/10 through 11/21/10, five (5) days. Review of the resident's medical record revealed no documented evidence the facility followed the Bowel Care Protocol. Further review revealed the facility failed to follow the Plan of Care related to administering as needed (PRN) medications as ordered and reporting if the resident had no bowel movement every two (2) to three (3) days. Interview with LPN #2 on 11/24/10 at 11:20 AM revealed if a resident did not have a bowel movement in three (3) days, the Bowel Protocol should be initiated. She stated she would not count a small bowel movement as adequate for most residents. She further stated the physician should be notified if there were no results after implementing the bowel protocol. Continued interview revealed all PRN medications administered, and results obtained after administering the medications, should be documented on the MAR.	F 309		
F 520 SS=G	483.75(e)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the	F 520	It is and was on the day of survey the policy at Oakmont Manor to maintain a Quality Assurance Committee that identifies issues and develops and implements plans of action to correct quality deficiencies.	

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F 520	Continued From page 19 facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to identify the failure to implement the facility's Bowel Care Protocol to ensure regular bowel movements for four (4) of nine (9) sampled residents (Residents #1, #3, #4 and #7). Residents #1, #3, #4, and #7 did not have adequate bowel movements, as defined per facility policy, for periods ranging from four (4) to twenty (20) days. Record review revealed the facility failed to follow their Bowel Care Protocol regarding the administration of medications and notification of physicians. The Quality Assurance Committee had not identified the system failure, and had not initiated corrective action to correct the deficiency.	F 520	1. Resident #1 no longer resides in the facility. Resident #3, #4, and #7 medical records have been reviewed and have bowel patterns established. This was completed on November 29, 2010 by the Unit Coordinator. 2. All other residents medical records have been reviewed to ensure a bowel pattern has been established and to determine MD notification had occured. This was completed on November 29th by the QA nurse. 3. All licensed staff have been educated by the Director of Nursing on December 6th on The Bowel Program and Notification of Changes to Physician. Audits are being completed daily by the Director of Nursing and/or QA nurse to determine timely Notification of Physician. audits are being completed on Mondays and Thursdays by the QA nurse to assure that all residents have had an adequate bowel movement in three days.	

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F 520	Continued From page 20 Resident #1 was hospitalized on 10/16/10, after failure to implement the Bowel Care Protocol, or notify the resident's physician regarding the lack of bowel movements by the resident. The resident was admitted with diagnoses including constipation and fecal impaction. The resident under surgical intervention and placement of a colostomy. The findings include: Review of the facility's Bowel Care Protocol (undated) revealed a resident must have at least one (1) large or two (2) medium bowel movements every three (3) days to be considered adequate. 1. Resident #1 was admitted to the facility on 09/24/10. Review of Bowel Information Tracking Logs for September and October of 2010 revealed no evidence Resident #1 had a bowel movement for eleven (11) days, from 09/24/10 to 10/04/10. The tracking log indicated the resident had a medium bowel movement on 10/07/10, a small bowel movement on 10/10/10, and a small bowel movement on 10/13/10. In addition, application of the Bowel Protocol to the tracking logs revealed the resident did not have an adequate bowel movement for twenty (20) days, from 09/24/10 to 10/14/10. There was no evidence the physician was notified regarding the resident's lack of bowel movements nor interventions implemented to ensure the resident had regular bowel movements. Review of hospital records, including an abdominal x-ray dated 10/16/10, and a Computerized Tomography (CT) scan, dated 10/16/10, revealed Resident #1 had a large	F 520	As part of the facility's ongoing Quality assurance program the Director of Nursing will review daily shift reports and nursing documentation to ensure all change of status has been reported to the physician. 4. The Quality Assurance Committee met on December 13th to review the results of the aforementioned audits and to determine compliance. All licensed nursing staff has been in-serviced on physician notification on December 6th by DON. The quality assurance committee will meet monthly for the next six months focusing on any changes in resident conditions. The daily audits conducted by the DON will be summarized and reported during the aforementioned meeting. December 14, 2010	

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F 520	Continued From page 21 amount of stool in the rectosigmoid portion of the colon, consistent with fecal impaction. In addition, hospital records indicated the resident underwent surgical intervention, with placement of a colostomy on 10/21/10. 2. Resident #3 was admitted to the facility on 05/18/09. Review of the resident's medical record revealed no documented evidence of an adequate bowel movement, per the facility's Bowel Care Protocol, from September 15 - October 2 (18 days), October 8-17 (10 days), and October 19-22 (4 days). During November, 2010, there was no evidence of an adequate bowel movement between October 26 and November 5 (11 days), and November 8 and November 23 (16 days). Review of the MAR for September and October of 2010 revealed no documented evidence the Bowel Care Protocol was followed with interventions implemented to ensure regular bowel movements. In addition, there was no evidence the physician was notified related to the resident's bowel status. 3. Record review revealed Resident #4 was admitted to the facility on 06/30/10. Review of Resident #4's medical record revealed no documented evidence of adequate bowel elimination from 08/13/10 through 08/19/10, five (5) days; from 08/31/10 through 09/06/10, six (6) days, 09/23/10 through 09/29/10, seven (7) days; 10/01/10 through 10/06/10, six (6) days; and 10/28/10 through 11/02/10, six (6) days. There was no evidence the facility followed the Bowel Care Protocol, including medication administered to ensure regular bowel movents, nor notification of the resident's physician regarding the lack of bowel movements.	F 520		

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F 520	Continued From page 22 4. Record review revealed Resident #7 was admitted to the facility on 09/28/04. Review of the resident's medical record revealed no documented evidence of adequate bowel elimination from 10/10/10 through 10/14/10, five (5) days; 10/16/10 through 10/19/10, four (4) days; 10/21/10 through 10/26/10, six (6) days; 10/28/10 through 11/03/10, seven (7) days; 11/06/10 through 11/10/10, five (5) days; and 11/17/10 through 11/21/10, five (5) days. there was no evidence facility staff implemented the Bowel Care Protocol for Resident #7. Interview with the Unit Manager where Residents #1, #3, and #7 reside, on 11/24/10 at 11:55 AM, revealed in addition to the Bowel Information Tracking Log, the facility utilized an additional form she referred to as the Bowel Log. She stated she reviewed the Bowel Log three (3) times a week, on Mondays, Wednesdays, and Fridays, but had not identified any concerns with the Bowel Care Protocol implementation. She further stated this log was an internal record and not part of the medical record. She described the Bowel Log as a communication tool between the Certified Medical Technicians (CMTs) and the nurses. Continued Interview with the Unit Manager (UM) revealed she considered one (1) medium bowel movement in three (3) days to be adequate. Upon reviewing the Bowel Care Protocol with the UM, she stated she had not been aware one (1) medium bowel movement was not adequate, per the facility's protocol. The UM was unaware Resident #1 had not had an adequate bowel movement for twenty (20) days. Interview with the CQI/QA Coordinator on	F 520		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185250	A. BUILDING _____ B. WING _____	C 11/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKMONT MANOR	1100 GRANDVIEW DRIVE, P O BOX 622 FLATWOODS, KY 41139

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 23 11/24/10 at 12:45 PM, revealed the committee met monthly to develop action plans for identified problems. She stated weekly meetings were held to check the progress of the plan. She explained since the introduction of the Minimum Data Set 3.0 Version on 10/01/10, the matrix was used to identify triggered areas for follow-up by the QA Committee. Continued interview revealed any areas on the matrix that fell in the 75th percentile were reviewed by the committee. The CQI/QA Coordinator explained that bowel management had not triggered for further review, and was not being tracked by the Committee.	F 520		